# Handbook for Providers of Transportation Services

# Chapter T-200
# Policy and Procedures for Transportation Services

Illinois Department of Healthcare and Family Services

# CHAPTER T-200
# MEDICAL TRANSPORTATION SERVICES
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## APPENDICES

# FOREWORD

## PURPOSE

This handbook has been prepared for the information and guidance of transportation providers who provide services to participants in the Department's Medical Programs. Contained in this handbook are both policy and procedures for emergency and non-emergency transportation services. This handbook provides information on how to access the Department's authorized agent for the transportation prior approval process.

Providers will be held responsible for compliance with all policy and procedures contained herein.

# CHAPTER T-200

# TRANSPORTATION SERVICES

## T-200 BASIC PROVISIONS

For consideration to be given by the Department for payment of transportation services, whether or not they are provided in an emergency, such services must be provided by an individual or company enrolled for participation in the Department's Medical Programs. Services provided must be in full compliance with both the general policy provisions contained in Chapter 100, General Policy and Procedures, and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

An approved provider is responsible for the safety and well-being of patients during the transport.

All non-emergency transportation requires approval except as specified in Topic T-211.

# T-201 PROVIDER PARTICIPATION

## T-201.1 PARTICIPATION REQUIREMENTS

Transportation providers eligible to be considered for participation are those who own or lease and operate any of the following:

- Ambulances licensed by the Illinois Secretary of State and inspected annually by the Illinois Department of Public Health (Vehicle Registration Type Ambulance).
- Helicopters possessing a special EMS license and an FAA Air Carrier Certificate issued by the United States Department of Transportation.
- Medicars licensed by the Illinois Secretary of State.
- Taxicabs licensed by the Illinois Secretary of State and, where applicable, by local regulatory agencies.
- Service cars licensed by the Illinois Secretary of State as livery or public transportation.
- Private automobiles licensed by the Illinois Secretary of State.
- Other specialized modes of transportation, such as buses, trains and commercial airplanes.

Drivers and vehicles must meet the Illinois Secretary of State licensing requirements.

Ambulance providers who provide services within Illinois must be in compliance with the EMS Systems Act (210 ILCS 50). Other transportation provider types based outside of Illinois must provide a valid license, permit or certification from the state where the business is headquartered.

Providers of transportation services are classified as emergency or non-emergency. Emergency transportation includes ambulance and helicopter providers. Non-emergency transportation includes medicar, taxicab, service car, private automobile, bus, train, and commercial airplane providers.

The provider must be enrolled for the specific category of service(s) (COS) for which charges are to be made. The categories of service for which a transportation provider may enroll are:

| COS | SERVICE DEFINITION |
|---|---|
| 50 | Emergency Ambulance - Transportation of a patient whose medical condition requires immediate treatment of an illness or injury.<br><br>The destination of an emergency ambulance is a hospital or another source of medical care when a hospital is not immediately accessible.<br>Or<br>Emergency Helicopter - Transportation of a patient when the responsible physician determines such mode to be a medical necessity. Such determination must be documented in writing by the physician. |
| 51 | Non-emergency Ambulance - Transportation of a patient whose medical condition requires transfer by stretcher and medical supervision. The patient's condition may also require medical equipment or the administration of drugs or oxygen, etc., during the transport. |
| 52 | Medicar - Transportation of a patient whose medical condition requires the use of a hydraulic or electric lift or ramp, wheelchair lockdowns, or transportation by stretcher when the patient's condition does not require medical supervision, medical equipment, the administration of drugs or the administration of oxygen, etc. |
| 53 | Taxicab - Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode. |
| 54 | Service Car - Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode. |
| 55 | Private Automobile - Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode. |
| 56 | Other Transportation - Transportation by common carrier, e.g., bus, train or commercial airplane. |

To participate, a transportation provider is required to enroll and file a provider agreement with the Department.

**PROCEDURE: The provider must complete and submit:**

- Form DPA 2243, Provider Enrollment Application Form.
- W9 Request for Taxpayer Identification Number.
- Form DPA 1413T, Medical Provider Agreement.

**The following documentation must be provided with the application, if appropriate.**

- Medicare Method of Payment - ambulance only.
- Copy of Secretary of State Vehicle Identification card.
- Copy of approved rate of reimbursement as established by local government authority.
- Copy of FAA Air Carrier Certificate.

Enrollment forms may be obtained from the Provider Participation Unit. E-mail requests for enrollment forms should be addressed to:

PPU@mail.idpa.state.il.us

Providers may also call the unit at 217-782-0538 or mail a request to:

Healthcare and Family Services

Provider Participation Unit

Post Office Box 19114

Springfield, Illinois 62794-9114

The forms must be completed (printed in ink or typewritten), signed and dated in ink by the provider, and returned to the above address. The provider should retain a copy of the forms.

**Participation approval is not transferable** - When there is a change in ownership of an enrolled transportation company, or a change in the Federal Employer's Identification Number or the Social Security number of an enrolled transportation provider, a new application for participation must be completed. Claims submitted by the new owner using the prior owner's assigned provider number may result in recoupment of payments and other sanctions.

**Fingerprint-Based Criminal Background Checks**- As part of the enrollment process, non-emergency transportation providers, excluding vendors owned or operated by governmental agencies and private automobiles, must submit to a fingerprint-based criminal background check as set forth in 89 Ill. Adm. Code 140.498.

## T-201.2 PARTICIPATION APPROVAL

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing the data in the Department's computer files. Refer to Appendix T-3 and T-3a. The information on the Provider Information Sheet is to be reviewed for accuracy immediately upon receipt. If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing billing forms.

The provider must correct any inaccuracies on the Department's file, as identified on the Provider Information Sheet. Refer to T-201.4 for the procedure to report change(s).

The Provider Participation Unit will assign the enrollment date.

Non-emergency transportation providers are subject to a 180-day probationary enrollment period as set out in 89 Ill Adm. Code 140.11.

## T-201.3 PARTICIPATION DENIAL

When participation is denied, the provider will receive written notification of the reason for denial.

Within ten (10) days after such notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten (10) days, or is received but later withdrawn, the Department's decision shall be a final and binding administrative determination. Department rules concerning the basis for denial of participation are set out in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

## T-201.4 PROVIDER FILE MAINTENANCE

The information carried in the Department’s files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

### Provider Responsibility

The information contained on the Provider Information Sheet is that carried in the Department’s files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. Inasmuch as the Provider Information

Sheet contains information to be used by the provider in the preparation of claims, the provider must immediately correct any inaccuracies found and notify the Department.

Any time the provider makes a change that causes information on the Provider Information Sheet to become invalid, the provider must notify the Department. When possible, notification should be made in advance of a change.

**Procedure**: The provider is to line out the incorrect or changed data, enter the correct data and sign the Provider Information Sheet on the line provided with an original signature. Forward the corrected Provider Information Sheet to:

Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Failure of a provider to properly notify the Department of corrections or changes may cause an interruption in participation and payments. In addition, the prior approval process may be interrupted if the Department's prior approval agent does not have correct information.

**Department Responsibility**

When there is a change in a provider's enrollment status or a change is submitted by the provider, the Department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to any payees listed if the address is different from the provider.

# T-202 TRANSPORTATION REIMBURSEMENT

## T-202.1 CHARGES

Charges made to the Department must be the provider's usual and customary charges as made to the general public for the same service.

## T-202.2 ELECTRONIC CLAIMS SUBMITTAL

Any services which do not require attachments or accompanying documentation may be billed electronically. Further information can be found in Chapter 100, Topic 112.3.

Providers should take special note of the requirement that Form 194-M-C, Billing Certification Form, which the provider will receive with the remittance advice, must be signed and retained by the provider for a period of three (3) years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies, or other adverse actions. Refer to Chapter 100, Topic 130.5 for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, the provider should contact the Department in the same manner as would be applicable to a paper claim. It may be necessary for the provider to contact their software vendor if the Department determines that the service rejections are being caused by the submission of incorrect or invalid data.

## T-202.3 CLAIMS PREPARATION AND SUBMITTAL

Refer to Chapter 100, Topic 112, for general policy and procedures regarding claim submittal. For general information on billing for Medicare covered services and submittal of claims for participants eligible for Medicare Part B, refer to Chapter 100, Topics 112.5 and 120.1. For information on billing for transportation services and submittal of claims for participants eligible for Medicare Part B, refer to Appendix T-2.

Form DPA 2209, Transportation Invoice, is to be used to submit charges for transportation services. Refer to Appendix T-1a for an example of a DPA 2209.

All services for which charges are made must be coded with specific procedure codes. Procedure codes and reimbursement rates for each transportation provider are listed on the Provider Information Sheet.

The Department uses a claim imaging system to scan paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendix T-1 for technical guidelines to assist in preparing paper claims for processing. The Department offers a claim scannability and imaging evaluation. Please send sample claims with a request for evaluation to the following address:

Healthcare and Family Services
201 South Grand Avenue East
Second Floor - Data Preparation Unit
Springfield, Illinois 62763-0001
Attention: Provider/Image System Liaison

The completed claims are to be submitted in a DPA 2244, Transportation Invoice Envelope, a pre-addressed mailing envelope provided by the Department. Use of this pre-addressed envelope will ensure that billing statements will arrive in their original condition and that they will be properly routed for processing.

When Form DPA 2209 Transportation Invoice is submitted with Form DPA 1411 Temporary MediPlan Card as an attachment, the invoice must be submitted in the pre-addressed envelope DPA 2248, Special Approval Envelope.

## T-202.31 Submittal of Emergency Helicopter Services

Providers of emergency helicopter services, including hospitals, should follow the instructions for claim preparation and submittal set out in Section T-202.3. In addition, the provider's record for each service must contain the air flight record and a physician's written statement that indicates the patient's diagnosis and medical need. A general statement such as "transport ordered by an M.D." or "transport to a higher level of care," is not sufficient.

## T-202.4 PAYMENT

Payment made by the Department for allowable medical transportation services provided to patients who are not eligible for Medicare will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the Department, pursuant to 89 Il. Adm. Code 140.492 and 140.493.

Payment made by the Department for ambulance or helicopter transportation services provided to patients who are eligible for both Medicare and Medicaid will be at the lower of the provider's usual and customary charge or the maximum rate as

established by the Department, pursuant to 89 Il. Adm. Code 140.493, or the Medicare allowable rate.

**Emergency helicopter** trips will be reimbursed using an all-inclusive rate depending upon whether the services are for transport team only, helicopter only or transport team and helicopter services.

Helicopter transportation providers who own the helicopter and provide their own transport team will be reimbursed at a maximum rate per trip or the usual and customary charges, whichever is less.

If a hospital provides the transport team but does not own the helicopter, the Department will equally divide the established reimbursement rate or the usual and customary charges of the providers, whichever is less, between the hospital and the helicopter provider.

Hospitals that own their own helicopter and report its costs on their cost reports will not be paid for helicopter transportation services. The Department shall not cover the services of helicopter transportation providers that have entered into payment agreements with receiving facilities.

Emergency helicopter transportation claims that are denied because the patient's condition does not meet medically necessary criteria, will be reimbursed by the Department at the appropriate ground rate.

**Ambulance** trips will be reimbursed using a base rate and a loaded mileage rate. When Basic Life Support **(BLS)** is provided, claims made for the administration of oxygen when medically necessary, will be paid at a maximum rate established by the Department, pursuant to 89 Il. Adm. Code 140.492.

**Advanced Life Support (ALS)** trips will be reimbursed using a base rate, loaded mileage rate, oxygen when medically necessary, and all ancillary charges at an all-inclusive maximum rate established by the Department, pursuant to 89 Il. Adm. Code 140.492. Payment for ALS is only made to providers who are certified for the service by the Illinois Department of Public Health.

= **Medicar** trips will be reimbursed using a base rate and a loaded mileage rate, pursuant to 89 Il. Adm. Code 140.492. Refer to T-210.1 for the Department's policy on billing mileage for additional passengers. Payment for an attendant, who is a person other than the driver, and non-emergency stretcher will be made at a maximum rate established by the Department, pursuant to 89 Il. Adm. Code 140.492. Refer to T-210.6 for the Department's policy regarding attendants.

= **Service Car** trips will be reimbursed at a base rate and a loaded mileage rate, pursuant to 89 Il. Adm. Code 140.492. Refer to T-201.1 for the Department's policy on billing mileage for additional passengers. Payment for an attendant, who is a person other than the driver, will be made at a maximum rate established by the

Department, pursuant to 89 Il. Adm. Code 140.492. Refer to T-210.6 for the Department's policy regarding attendants.

**Taxicab** trips will be reimbursed at the community rate, as set by local government or if no regulated local government rates exists, at a maximum rate established by the Department, pursuant to 89 Il. Adm. Code 140.492. Payment for an attendant, who is a person other than the driver, will be made at a maximum rate established by the Department, pursuant to 89 Il. Adm. Code 140.492. Refer to T-210.6 for the Department's policy regarding attendants.

**Private Auto** trips will be reimbursed at a loaded mileage rate as set by the Department, pursuant to 89 Il. Adm. Code 140.492.

**Unique or Exceptional Modes of Transportation** may be reimbursed at a negotiated rate.

Billing of excess mileage is not allowed. In performing audits, the Department verifies mileage with a travel route software package.

## T-202.5 FEE SCHEDULE

The Department's list of allowable procedure codes by provider type are listed on the Department's Web site. The listing can be found at

http://www.hfs.illinois.gov/reimbursement/

Paper copies of the listings can be obtained by sending a written request to:

Healthcare and Family Services
Bureau of Comprehensive Health Services
201 South Grand Avenue East
Springfield, IL 62763-0001

The fee schedule is also available electronically. The Department maintains a downloadable rate file suitable for use in updating a provider's computerized billing system. This file is located in the same area on the Department's Web site as the listings described above. A copy of this file can also be obtained by sending a blank 3.5 inch IBM PC compatible diskette, a written request and a self-addressed, prepaid diskette mailer to the address listed above.

Procedure codes and reimbursement rates for each transportation provider are listed on the Provider Information Sheet. Anytime a change in procedure codes or rates is made, the provider will receive an updated provider information sheet.

# T-203 COVERED SERVICES

A covered service is a service for which payment can be made by the Department. Refer to Chapter 100, Topic 103. If the transportation is subject to prior approval by the Department, payment will be made only if prior approval has been given. Refer to Topic T-211.

Transportation of a patient to or from a covered source of medically necessary care is covered and payment can be made only if a cost-free mode of transportation is not available or is not appropriate.

Oxygen usage is a covered service when medically necessary and administered in the transport of a patient by ambulance.

The use of an attendant in the transport of a patient by a medicar, service car or a taxi is a covered service when medically indicated. The use of an attendant for transport is subject to the Department's transportation prior approval process in most instances. Refer to Topic T-210.6 for the Department's policy regarding the use of an attendant.

The use of a stretcher in a medicar is a covered service for non-emergency transport when the medical need of the patient does not require a higher level of special medical services, i.e., paramedics, emergency medical technicians, medical equipment and supplies, or the administration of drugs or oxygen.

Basic Life Support (BLS) is a covered service when the patient's medical condition requires BLS according to the rules and regulations of the Illinois Department of Public Health. A BLS ambulance provides transportation plus the equipment and staff for basic services such as giving first aid, controlling bleeding, administering oxygen, treatment of shock, taking vital signs or administering cardiac pulmonary resuscitation (CPR).

Advanced Life Support (ALS) is a covered service when the patient's medical condition requires ALS according to the rules and regulations of the Illinois Department of Public Health. An ALS ambulance provides all basic ambulance services and typically has complex life-sustaining equipment and radio or telephone contact with a physician or hospital. An ALS ambulance will have equipment and staff to provide services such as administration of appropriate drugs, intravenous therapy, airway intubation, or defibrillation of the heart.

Ambulance services must be billed at the appropriate level of service (ALS or BLS) necessary for the patient's medical condition.

Emergency helicopter transport service is a covered service when the patient's medical condition is such that immediate and rapid transportation cannot be provided by ground ambulance. An emergency may include, but is not limited to:

- life threatening medical conditions;
- severe burns requiring treatment in a burn center;
- multiple trauma;
- cardiogenic shock; and
- high-risk neonates.

## T-204 NON-COVERED SERVICES

Certain medical services are not covered in the scope of the Department's Medical Programs and payment cannot be made for transportation to and from such services. Refer to Chapter 100, Topic 104 for a general list of non-covered services.

The Department does not reimburse for transportation provided in connection with any services not reimbursed by the Department's Medical Programs, such as early intervention services, sheltered workshops, day care programs, social rehabilitation programs or day training services. In these instances, transportation providers must verify reimbursement sources prior to delivery of services with the entity requesting the service.

Additionally, payment will not be made by the Department for the following:

- Non-emergency transportation where Department prior approval is required but has not been obtained.
- Services medically inappropriate for the patient's condition (e.g., a taxi when public transportation is available and medically appropriate or a medicar when a service car is warranted).
- Services of a paramedic, emergency medical technician, or nurse in addition to the BLS or ALS rates.
- Transportation of a person having no medical need, other than an attendant. Refer to Topic 210.6 for the policy regarding the use of an attendant.
- "No Show" trips (i.e., patient not transported).
- Trips for filling a prescription or obtaining medical supplies, equipment or any other pharmacy-related item.
- Charges for mileage other than loaded miles.
- Transportation of a person who has been pronounced dead by a physician or where death is obvious.
- Charges for waiting time, meals, lodging, parking, tolls.
- Transportation provided in vehicles other than those owned or leased and operated by the provider.
- Transportation services provided for a hospital inpatient who is transported to another medical facility for outpatient services not available at the hospital of origin and the return trip to the in-patient hospital setting. In this instance, the transportation provider must seek payment from the in-patient hospital.
- Transportation to receive services when a patient is a current member of a Managed Care Organization (MCO). Refer to Topic 210.4 for prior authorization information.
- Services provided by a hospital owned and operated transportation provider where the transportation costs are reported in the hospital's cost report for the following:

- Transportation services provided on the date of admission and the date of discharge.
- Transportation services provided on the date that an ambulatory procedures listing (APL) service is performed or an emergency room visit is made.

# T-205 RECORD REQUIREMENTS

Refer to Chapter 100, Topic 110.1 for information regarding the maintenance of records and Topic 110.2 regarding the retention of records. The transportation provider's basic record must, at a minimum, contain a dispatcher's log and individual trip ticket which documents the following:

- Identification of the participant (name, address and recipient identification number (RIN).
- Name and address of person requesting the service. Anyone may make this request, including, but limited to, the patient, the transportation provider or the provider of medical care.
- Copy of the Transportation Invoice.
- Identification of the type of vehicle used, (i.e., ambulance, medicar, service car, etc.) and the vehicle's license plate number.
- Name of the driver and attendant, if applicable.
- Medical necessity must be documented for the following circumstances:
  - Non-emergency transportation which does not require prior approval; Refer to Topic 210.2,
  - Use of an ambulance,
  - Administration of oxygen by an ambulance provider and,
  - Use of an attendant by a medicar, service car or a taxicab provider,
  - Use of a stretcher by a medicar provider.

A sample uniform trip ticket can be found in Appendix T-4. The Department does not issue this form or require that providers use it for documentation.

When appropriate, the records must also contain the following documents:

- FAA Air Carrier Certificate issued by the U.S. Department of Transportation
- A physician's statement indicating the patient's diagnosis and medical necessity.
- The air flight record for emergency helicopter services.

In addition, ambulance providers must document the medical necessity for the transport on the trip ticket. Providers of Advanced Life Support transportation must include a copy of the Emergency Medical Services Run Sheet or other form as required by the Illinois Department of Public Health.

The Department and its professional advisors regard the preparation and maintenance of adequate medical records as essential for the delivery of quality medical care. In addition, providers should be aware that medical records are a key document for post payment audits.

In the absence of proper and complete medical records no payments will be made and payments previously made will be recouped.

# T-210 GENERAL LIMITATIONS AND CONSIDERATIONS ON COVERED SERVICES

Transportation approval will be given for the least expensive mode of transportation available that is appropriate for the participant. When public transport is available and there is no medical condition to prevent the participant from using public transport, the patient may obtain public transportation passes from the local Illinois Department of Human Services (DHS) offices.

## T-210.1 ADDITIONAL PASSENGERS

Anytime more than one passenger is transported in the same vehicle for any portion of a trip, the transportation provider may only charge mileage for the first passenger.

Procedure:

- A separate DPA 2209 provider invoice must be filed for each passenger.
- Allowable ancillaries, if provided, and the base rate may be charged for each passenger.
- Mileage may only be charged for the first passenger picked up. The mileage charge is limited to the most direct (shortest) route between the origination address and the destination address for the first passenger, no matter how far the first passenger travels.
- Mileage may not be charged for another passenger until the vehicle is empty. (See example below)

**Example:**

| Person | Pick-up Location | Drop-off Location | Claim Submittal |
|---|---|---|---|
| 1 | A | C | Charge base rate and direct mileage from A to C (the additional mileage to pick-up persons 2 and 3 should not be included in the mileage submitted on the claim) |
| 2 | B | C | Charge base rate |
| 3 | B | D | Charge base rate |
| 4 | D | E | Charge base rate and direct mileage from D to E |
| **Note:** When Person 3 is dropped off the vehicle is empty. Therefore, the provider may charge mileage for Person 4. Allowable ancillaries, if provided, may be charged for each person. | | | |

## T-210.2 RESIDENTS OF LONG TERM CARE FACILITIES (LTC)

**Reimbursed by the Department -** Prior approval is not required for transportation of participants who reside in a LTC facility. This does not include participants who reside in sheltered care facilities or participants enrolled in an MCO. Providers have the responsibility for verifying the appropriate mode of transportation, the participant's eligibility and the origin and destination prior to accepting the participant for transport.

**Not Reimbursed by the Department -** The Department may not be billed when a participant who is a resident of a LTC Facility is transported for services other than covered medical services. This includes, but is not limited to, transportation to a sheltered workshop or a day training center. The transportation provider should look to the training center or workshop for compensation. Refer to Topic T-204.

## T-210.3 HOSPITAL-BASED (OWNED) AMBULANCE

Hospitals that own and operate medical transportation vehicles as a corporation separate from the hospital entity must enroll as a medical transportation provider under the appropriate provider type. All policies and procedures contained in this handbook apply.

Hospitals that own and operate medical transportation vehicles that are included as a cost center of the hospital are required to enroll as a medical transportation provider under provider type 74, Hospital-Based Transportation. Refer to Topic T-204 for non-covered services. Transportation services may be billable in the following instances:

- The origin or destination of the trip is outpatient hospital for primary care physician services.
- The origin or destination of the trip is a source of medical care other than the hospital that owns the transportation service.

## T-210.4 PARTICIPANTS ENROLLED WITH A MANAGED CARE ORGANIZATION (MCO)

All non-emergency transportation services for participants enrolled in a MCO must be prior approved by the MCO when transport is needed for medical services covered by the MCO. To obtain prior approval for non-emergency transportation for participants enrolled with an MCO, the MCO must be contacted. The phone number for the MCO is printed on the participant's MediPlan or KidCare card. MCOs have medical personnel available 24 hours a day to provide prior approval.

Prior approval from the MCO is not required in the following circumstances:

- Emergency services do not require prior approval.

- Participants are not limited to in-network providers for family planning services. If the participant seeks family planning services outside of the MCO network, then the Department's transportation approval agent must be contacted for approval of the transport rather than the MCO. Refer to Topic T-211.
- Transport for services not covered by the MCO plan, such as, dental and vision services. Contact the Department's transportation approval agent. Refer to Topic T-211.

## T-210.5 DEPARTMENT OF CHILDREN AND FAMILY SERVICES WARDS (DCFS)

Special procedures are used to approve non-emergency medical transportation for children who are in the care and custody of the Illinois Department of Children and Family Services (DCFS). Except for children receiving Screening, Support and Assessment Services (SASS), only DCFS medical liaisons may make non-emergency medical transportation arrangements for DCFS wards.

For children enrolled in the SASS program, SASS must authorize non-emergency medical transportation arrangements for services prescribed in their SASS treatment plan. If a transportation provider experiences difficulties in securing approval from the SASS provider for a non-emergency transport of a DCFS child to a SASS-related covered medical service, the provider may contact the DCFS medical liason to request assistance. To identify the DCFS medical liason, contact the child's DCFS caseworker or DCFS at 1-800-228-6533 to request the name and phone number of the medical liason located in the DCFS ward's region.

## T-210.6 COVERAGE OF AN EMPLOYEE ATTENDANT AND A NON-EMPLOYEE ATTENDANT

An employee attendant is defined as a person, other than the driver, who is an employee of a medicar company. A non-employee attendant is defined as a family member or other individual who may accompany the participant when there is a medical need for an attendant.

= An **employee attendant** or a **non-employee attendant** is a covered service when the mode of transportation is a medicar, service car, or taxicab, and the circumstances constitute a medical necessity, as provided below.

The Department will pay for an attendant to accompany an eligible patient to and from the source of a covered medical service in the following circumstances:

- To go with the patient to a medical provider when needed, such as parent going with a child to the doctor or when an attendant is needed to assist the patient;
- To participate in the patient's treatment when medically necessary; or
- To learn to care for the patient after getting out of the hospital. The Department does not pay for transportation of family members to visit a hospitalized patient.

The use of an employee and a non-employee attendant is subject to prior approval in all situations except for those non-emergency trips described in Topic T-211. In the instances that prior approval is not required for an attendant, medical necessity must be documented in the record.

The Department's authorized approval agent may request documentation of medical necessity.

= The attendant procedure code(s) used to bill for employee and non-employee attendants is contained in section 6 of the Provider Information Sheet. Refer to Appendix T-3a for a facsimile of the Provider Information Sheet.

# T-211 APPROVAL FOR NON-EMERGENCY TRANSPORTATION

The Department has contracted with a prior approval agent to operate a centralized transportation prior approval process.

Except as listed below, prior approval is required for all non-emergency transportation services to and from a source of medical care covered by the Department's Medical Programs.

Prior approval is not required for:

- Emergency ambulance and helicopter services (Category of Service 50).
- Medical transportation provided for patients who reside in Long Term Care (LTC) Facilities. For purposes of prior approval or requests for transportation services, LTC facilities are defined as:
    - Nursing Facilities or Skilled Nursing Facilities - Provider Type 33
    - Intermediate Care Facilities for the Mentally Retarded (ICF/MR) - Provider Type 29
    - Supportive Living Facilities (SLF) - Provider Type 28
    - State Operated Facilities - Provider Type 34
- Ambulance service from one hospital for admission to a second hospital to receive inpatient services, which are not available at the sending hospital.

In situations when prior approval is not required, providers have the responsibility for verifying the appropriate mode of transportation, the participant's eligibility and the origin and destination prior to accepting the participant for transport.

## T-211.1 PRIOR APPROVAL FOR NON-EMERGENCY TRANSPORTATION

Healthcare and Family Services contracts with First Transit Inc. to provide prior approvals of requests for non-emergency transportation services. To request a prior approval, contact First Transit Inc. at 1-877-725-0569, TTY 1-877-204-1012, Monday - Friday 8:00 AM - 5:00 PM. Requests for approvals must be made at least two (2) business days prior to the date the transportation service is needed. "Business days" means Monday through Friday and does not include Saturdays, Sundays and holidays.

A standing approval, with a duration of up to six (6) months, may be obtained when subsequent trips to the same medical source are required based on standing orders for specific medical services. When approval is sought for subsequent trips to the same medical source, the patient's physician or other health professional must supply the Department's authorized transportation approval agent with a written statement describing the nature of the medical need, the necessity for on-going visits, already established appointment dates and the number and expected duration of the required on-going visits.

**Approval Procedures** - A request for transportation is initiated to the Department's transportation approval agent by a participant, the transportation provider or the medical services provider.

The approval should be requested at least two (2) business days in advance because additional information may be required to make a determination.

The transportation approval agent will require the following information to determine whether the requested transportation is approved:

Name of the participant needing transportation.
Participant's recipient identification number (RIN).
Date and time of the medical appointment.
Medical provider name and address.
Specific purpose of the appointment.
Information to determine the level of transportation needed.
Transportation provider name and provider number.

An approval does not guarantee payment. The participant for whom transportation is approved must be eligible at the time each service is provided.

Approval will be given for the least expensive mode of transportation which is adequate to meet the participants' medical needs. The Department reserves the right for its authorized transportation approval agent to determine the appropriate mode of transportation and if necessary, to assist the participant in obtaining a transportation provider.

## T-211.2 POST APPROVAL FOR NON-EMERGENCY TRANSPORTATION

In the event it is not possible to obtain prior approval for non-emergency transportation, post approval must be requested.

For dates of service on, and before, December 31, 2005, post approval requests must be received by the transportation approval agent no later than ninety (90) calendar days after the date(s) of service and must include the information required for a prior approval.

For dates of service on, and after, January 1, 2006, post approval requests must be received by the transportation approval agent no later than fifteen (15) business days after the date(s) of service and must include the information required for a prior approval.

Requests for post approvals are subject to the same criteria as those for prior approvals as stated in Topic T-211.1.

Exceptions to the post approval deadline will be permitted in the following instances:

- The Department or the DHS local office has received the patient's Medical Assistance or KidCare application, but approval of the application has not been issued as of the date of service. In such a case, the post approval request must be received by the approval agent no later than ninety (90) calendar days following the date of the Agency's Notice of Decision approving the application.

- The participant did not inform the provider of his or her eligibility for Medical Assistance or KidCare. In such a case, the post approval request must be received by the approval agent no later than six (6) months following the date of service, but will be considered for payment only if there is attached to the request a copy of the provider's dated, private pay bill or collection correspondence, which was addressed and mailed to the participant each month following the date of service.

## T-211.3 PRIOR APPROVAL NOTIFICATION

If the requested transportation service is approved, the transportation provider will receive a computer-generated letter, form DPA 3076F, Notice of Approval for Transportation Services, listing the approved service(s). The transportation provider must review the Notice of Approval for Transportation Services for accuracy. If there are errors on the Notice, such as incorrect Origin and Destination Codes, First Transit must be contacted to correct the posted approval.

The transportation claim submitted must match the services that appear on the form DPA 3076F, Notice of Approval for Transportation Services, or the claim will be rejected.